CPD-2B, REV 8/03

For Official Use Only

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
Drug Control Division (860) 713-6065
Web Site: www.state.ct.us/dcp/

CONTROLLED SUBSTANCE REGISTRATION FOR PRACTITIONERS

➡ **Return completed application and fee to:**

Department of Consumer Protection
License Services Division
165 Capitol Avenue
Hartford, CT 06106

Make check payable to:
"Treasurer, State of CT"

Fee Due: $ 10.00

➔**Note:** Upon approval of this application a registration will be sent to you. Your effective date will be the date your application is approved. **All registrations expire annually on February 28th.**

Name (First Name, Middle Initial, Last Name)			Title
Street Address	City	State	Zip Code
Telephone Number (w/ area code)	Date of Birth	Social Security Number	Email Address

Professional License Number (From State Public Health Dept)	Federal DEA Number (From Federal Drug Enforcement Admin)

Registration Classification: (Check one (1) only)
☐ Practitioner ☐ Hospital ☐ Clinic ☐ Resident ☐ Intern ☐ Other (Specify) _____

Drug Schedules:
☐ *Schedule I* (Reasearch) ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

Is the applicant currently authorized to prescribe, administer, dispense, or otherwise handle controlled substances in schedules checked below under Connecticut state law? ☐ Yes ☐ No

Has the applicant ever been covicted of any criminal charge under Federal or State controlled drug laws?
☐ Yes ☐ No *If yes, complete the Letter of Explanation on the back of this form*

Has any Federal or State registration held by the applicant been surrended, revoked, suspended, limited, denied or is any such action pending? ☐ Yes ☐ No *If yes, complete the Letter of Explanation on the back of this form*

Is the applicant an officer or employee of a Federal, State or Municipal Government agency who is exempt from payment of registration fee? ☐ Yes ☐ No

If **YES,** complete the following:

FOR FEE EXEMPT ONLY:

Note: Registration fee is required with this application if the applicant prescribes, administers or dispenses controlled substances in any capacity not related to his/her Governmental duties. Signature of a Supervisor is required for exemption.

NAME OF FACILITY OR GOVERNMENT AGENCY: _____

ADDRESS: _____

SUPERVISOR'S SIGNATURE: _____ TITLE: _____

I certify that the information contained in this application is the truth to the best of my knowledge.

Signature of Applicant _____ **Date** _____

LETTER OF EXPLANATION